112TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 112–715
Part 1

STRENGTHENING MEDICARE AND REPAYING TAXPAYERS ACT OF 2012

DECEMBER 20, 2012.—Ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 1063]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1063) to amend title XVIII of the Social Security Act with respect to the application of Medicare secondary payer rules for certain claims, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

AMENDMENT

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Strengthening Medicare And Repaying Taxpayers Act of 2012".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. DETERMINATION OF REIMBURSEMENT AMOUNT THROUGH CMS WEBSITE TO IMPROVE PROGRAM EFFICIENCY.

Section 1862(b)(2)(B) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

"(vii) USE OF WEBSITE TO DETERMINE FINAL CONDITIONAL REIMBURSEMENT AMOUNT.—

"(I) NOTICE TO SECRETARY OF EXPECTED DATE OF A SETTLEMENT, JUDGMENT, ETC.—In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

"(II) SECRETARY PROVIDING ACCESS TO CLAIMS INFORMATION THROUGH A WEBSITE.—The Secretary shall maintain and make available to individuals to whom items and services are furnished under this title (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that are attributable to a specific injury or incident that forms the basis for a settlement, judgment, award or other payment relating to an injury or incident to which this subsection applies. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as possible but not later than 15 days after the date of receipt of such claims or the making of such payments, respectively. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

"(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

"(bb) The information accurately identifies those claims and payments that are related to an injury or incident to which the provisions of this subsection apply.

"(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

"(dd) The website provides that information is transmitted from the website in a form that includes an official time and date that the information is transmitted.

"(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a 'statement of reimbursement amount') on payments for claims under this title relating to a specific injury or incident of the individual.

"(III) USE OF TIMELY WEB DOWNLOAD AS BASIS FOR FINAL CONDITIONAL AMOUNT.—If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during

such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

"(IV) RESOLUTION OF DISCREPANCIES.—If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide an alternate final conditional payment amount and documentation of the basis for such alternate amount. Within 15 days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis for such alternate final conditional payment amount. If the Secretary does not make such determination within the 15-day period, then the alternate final conditional payment amount shall become the final conditional payment amount. If the Secretary determines within such period that there is not a reasonable basis for the alternate amount, the original final conditional payment amount is reconfirmed. If the Secretary determines within such period that there is a reasonable basis for an alternate final conditional payment amount, the Secretary must respond in a timely manner by agreeing to the alternative final conditional payment amount or by providing documentation showing with good cause why the Secretary is not agreeing to such amount and either reconfirming the original final conditional payment amount or establishing another alternative final conditional payment amount. In no case shall the process under this subclause be treated as an appeals process or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

"(V) PROTECTED PERIOD.—In subclause (III), the term 'protected period' means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

"(VI) EFFECTIVE DATE.—The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after the date of the enactment of this clause.

"(VII) WEBSITE INCLUDING SUCCESSOR TECHNOLOGY.—In this clause, the term 'website' includes any successor technology.

"(viii) RIGHT OF APPEAL FOR SECONDARY PAYER DETERMINATIONS RELATING TO LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS.—The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this title for an item or service for which the Secretary is seeking to recover funds from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii), under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination.".

SEC. 3. FISCAL EFFICIENCY AND REVENUE NEUTRALITY.

(a) IN GENERAL.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (2)(B)(ii), by striking "A primary plan" and inserting "Subject to paragraph (9), a primary plan"; and

(2) by adding at the end the following new paragraph:

"(9) EXCEPTION.—

"(A) IN GENERAL.—Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

"(B) ANNUAL COMPUTATION OF THRESHOLDS.—Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. Each such annual single threshold amount for a year shall be set such that the expected average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments for each of liability insurance (including self-insurance), workers' compensation laws or plans, and no fault insurance subject to this section shall equal the expected cost of collection incurred by the United States (including payments made to contractors) for a conditional payment from each of liability insurance (including self-insurance) and alleged physical trauma- based incidents (excluding alleged ingestion, implantation or exposure cases) subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for a year, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount. The Secretary shall include, as part of such publication for a year—

"(i) the expected cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation or exposure cases; and

"(ii) a summary of the methodology and data used by the Secretary in computing each such threshold amount and such cost of collection.

"(C) TREATMENT OF ONGOING EXPENSES.—For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) involving the ongoing responsibility for medical payments, such payment shall include only the cumulative value of the medical payments made.

"(D) REPORT TO CONGRESS.—Not later than November 15 before each year, the Secretary shall submit to the Congress a report on a single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from each of liability insurance (including self-insurance) claims for ingestion, implantation and exposure cases, workers compensation cases, and no fault insurance cases subject to this section for that year. For each such report, the Secretary shall—

"(i) calculate each such threshold amount by using the methodology described in subparagraph (B); and

"(ii) include a summary of the methodology and data used in calculating each such threshold amount and the amount of expected savings under this title achieved by the Secretary implementing such thresholds.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to years beginning more than 4½ months after the date of the enactment of this Act.

SEC. 4. REPORTING REQUIREMENT.

Section 1862(b)(8) of the Social Security Act (42 U.S.C. 1395y(b)(8)) is amended—

(1) in the first sentence of subparagraph (E)(i), by striking "shall be subject" and all that follows through the end of the sentence and inserting the following: "may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant."; and

(2) by adding at the end the following new subparagraph:

"(I) REGULATIONS.—Not later than 60 days after the date of the enactment of this subparagraph, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.".

SEC. 5. USE OF SOCIAL SECURITY NUMBERS AND OTHER IDENTIFYING INFORMATION IN REPORTING.

Section 1862(b)(8)(B) of the Social Security Act (42 U.S.C. 1395y(b)(8)(B)) is amended by adding at the end (after and below clause (ii)) the following:

"Not later than 18 months after the date of enactment of this sentence, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.".

SEC. 6. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Section 1862(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(B)(iii)) is amended by adding at the end the following new sentence: "An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment, award, or other payment made pursuant to paragraph (8) relating to such payment owed.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to actions brought and penalties sought on or after 6 months after the date of the enactment of this Act.

PURPOSE AND SUMMARY

H.R. 1063 creates efficiencies in the Medicare Secondary Payer program that support beneficiary settlements and speed up the process of returning money to the Medicare Trust Fund.

BACKGROUND AND NEED FOR LEGISLATION

The Medicare Trust Fund (through the Centers for Medicare and Medicaid Services (CMS)) has the right to recover Medicare payments that should have been the responsibility of another payer.

Congress authorized the Medicare Secondary Payer program in 1980 (§ 1862(b) of the Social Security Act), which identified specific conditions under which Medicare is the secondary payer. Those are (1) a group health plan based on their own or a spouse's current employment; (2) individuals with Medicare coverage based solely on ESRD; (3) auto and other liability insurance; (4) no-fault liability insurance; and (5) workers' compensation situations, including the Black Lung program.

CMS has not always been aware of situations where Medicare should not pay first, and as a result, Medicare has paid for services that were the financial responsibility of another payer. To address

this particular issue, in 2008, Congress added mandatory reporting provisions for GHPs and NGHPs through the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Such provisions are designed to ensure Medicare is aware of situations where the Trust Fund is owed money.

Mandatory reporting was initially supposed to begin in 2009. CMS pushed the effective date to 2011 (for workers' compensation and no-fault insurers) and to 2012 (for other NGHPs, including most liability insurers), in part because of concerns raised by the industry. Previously, the industry had little or no interaction with the Medicare program, and raising awareness of the new requirements and how to comply with them took some time.

With the new reporting requirements enacted under MIPAA, CMS should be able to identify which payments have been made by Medicare that should have been the primary responsibility of another payer, and therefore should be recovered, as well as situations in which CMS should avoid making Medicare payments when another payer is the primary. The requirements also included penalties for non-compliance with reporting. At the time, these requirements were estimated to save Medicare $1.1 billion over 10 years.

In most situations involving NGHPs, Medicare will initially pay for medical treatment related to the incident, and later seek to recover those payments. This occurs sometimes because treatment is provided before CMS is notified of the MSP situation. However, in most instances, CMS will continue to pay for the beneficiary's services while the situation is in resolution so that the beneficiary has access to needed medical services in a timely manner. These payments are called "conditional payments." Once a beneficiary and NGHP reach resolution, Medicare will seek to recover any conditional payments made.

Congress has amended the MSP statute a number of times since 1980 in order to improve the program. However, the Committee is aware of problems and inefficiencies in the program.

Many MSP claims today still cannot be settled in a timely or conclusive manner for beneficiaries. Under current law, there is no requirement for CMS to provide the parties with amounts due or the amount they should set aside to cover future payments before settlement so the parties can allocate appropriately and resolve these Medicare obligations during settlement.

In response to confusion and concerns raised on the part of stakeholders once mandatory reporting began, CMS has made a number of improvements to the process for reporting settlements and getting a final conditional payment amount.

Some of CMS's recent efforts include:

• On June 30, 2011, CMS established a minimum threshold of $25 for all recovery demands. (This is consistent with the threshold used by the Department of Treasury for collecting delinquent debt pursuant to the Debt Collection Improvement Act of 1996.)

• On September 6, 2011, CMS implemented a $300 threshold for certain liability settlements. When established criteria are met, reporting and repayment is not required if the settlement is for $300 or less.

• On September 30, 2011, the Medicare Secondary Payer Recovery contractor implemented a self-service information feature to its

customer service line. This feature gives callers the ability to get the most up-to-date demand/conditional Payment amounts, and the dates that those letters were issued, without having to speak to a customer service representative. The self-service feature is available for extended hours, and callers have the option of requesting information on multiple cases during one phone call.

• Effective November 7, 2011, CMS implemented a simple fixed percentage option for certain types of settlements of $5,000 or less. Under this option, the beneficiary/representative can elect to pay Medicare 25% of the settlement to resolve Medicare's recovery claim.

• On February 21, 2012, CMS implemented a process for certain settlements of $25,000 or less, where the beneficiary/representative can self-identify its conditional payment amount to Medicare prior to finalizing a settlement. If all criteria are met, Medicare will respond to the beneficiary within 60 days providing Medicare's final conditional payment amount prior to settlement.

• CMS implemented a Medicare Secondary Payer Recovery portal on July 2, 2012. The beneficiary can use this portal to obtain information about Medicare's claim payments, conditional payment amounts, etc., and input information related to authorizations, settlements, disputed claims, etc.

While these improvements are designed to give the beneficiary finality with regard to certain settlements without eliminating Medicare's control over its own processes, the Committee remains concerned about the need for additional improvements to the process.

HEARINGS

On June 22, 2011, the Subcommittee on Oversight and Investigations held a hearing entitled "Protecting Medicare with Improvements to the Secondary Payer Regime." At the hearing, the Subcommittee examined the Medicare Secondary Payer system as well as methods to improve the Medicare program and protect the fiscal integrity of Medicare. The Subcommittee received testimony from:

- Ms. Deborah Taylor, Director of Financial Management Centers for Medicare and Medicaid Services;
- Mr. James Cosgrove, Director of Health Care, Government Accountability Office;
- Mr. Marc Salm, Vice President of Risk Management, Publix Supermarkets, Inc.;
- Mr. Scott Gilliam, Vice President, Cincinnati Insurance Company;
- Mr. Jason Matzus, Partner, Raizman Frischman & Matzus, P.C.; and
- Ms. Ilene Stein, Federal Policy Director, Medicare Rights Center.

COMMITTEE CONSIDERATION

On September 13, 2012, the Subcommittee on Health met in open markup session and favorably forwarded H.R. 1063 to the full Committee, as amended, by a voice vote, a quorum being present.

On September 20, 2012, the full Committee met in open markup session and ordered H.R. 1063 favorably reported to the House, as amended, by a voice vote, a quorum being present.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the recorded votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 1063 reported.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a hearing on the Medicare Secondary Payer program and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of H.R. 1063 is to improve the Medicare Secondary Payer system to improve the process of recouping Medicare Trust Fund money by encouraging speedier settlements, reducing unnecessary burdens currently that delay or stop settlements from going forward, and encouraging timely restitution for beneficiaries who have been injured through no fault of their own.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 1063 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI, the committee finds that H.R. 1063 contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

H.R. 1063—Strengthening Medicare and Repaying Taxpayers Act of 2011

Summary: H.R. 1063 would modify the process through which the Medicare program is reimbursed when another payer (for example, a liability insurer) is responsible for a beneficiary's medical costs. In general, the provisions of H.R. 1063 would make it easier for other payers to repay Medicare, thus reducing program costs.

CBO estimates that enacting H.R. 1063 would reduce Medicare spending by $45 million over the 2013–2022 period. Pay-as-you-go

procedures apply because enacting the legislation would affect direct spending.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1063 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By fiscal year, in millions of dollars—											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013–2017	2013–2022
CHANGES IN DIRECT SPENDING												
Estimated Budget Authority ..	−2	−4	−4	−4	−4	−5	−5	−5	−6	−6	−18	−45
Estimated Outlays	−2	−4	−4	−4	−4	−5	−5	−5	−6	−6	−18	−45

Basis of estimate: The estimate assumes that the bill would be enacted late in calendar year 2012 and that its provisions would take effect by the end of fiscal year 2013. Medicare is the "secondary payer" when another insurer has an obligation to pay for certain health spending by beneficiaries. For example, if a Medicare beneficiary is injured in a car accident, auto liability insurance is usually responsible for any resulting medical bills. Because establishing an insurer's obligation to pay can be time-consuming, the Medicare program will often pay for a beneficiary's medical costs until it can be determined which payer is liable for the costs. In such cases, Medicare makes "conditional" payments and seeks reimbursement from the other insurer.

Section 2 of H.R. 1063 would modify the process through which beneficiaries and responsible insurers determine how much the Medicare program is owed for conditional payments. Beneficiaries, or their representatives, would be able to query a secure Web site and receive an estimate of Medicare's conditional payments. That amount would be factored into the settlement between the beneficiary and the insurer, allowing certainty about the amount that will be paid to Medicare out of the settlement funds for conditional payments made to that point.

CBO analyzed data from stakeholders with respect to the difference in settlement timeliness between Medicare and non-Medicare cases and the dollar value of settlements for Medicare beneficiaries. CBO estimates that section 2 would allow some settlements to occur more quickly and hasten repayment to Medicare. With respect to the number of settlements that occur, CBO estimates that section 2 will have two opposing effects: some cases would settle that otherwise would not, because of the easier access to information about the amount of the conditional payment, and some settlements would include a payment amount that is lower than it would be under current law because of the timing of the determination of the conditional payment. CBO estimates that the net effect of those two opposing effects would result in a slight reduction in outlays over the 2013–2022 period.

Section 3 would exempt insurers from repaying Medicare for certain small claims. Based on information from the Medicare Secondary Payer Contractor, CBO believes that section 3 would codify current practice and thus would have no budgetary impact.

H.R. 1063 would change current law with respect to civil monetary penalties, which may be levied on insurers that do not report

on a timely basis their obligation to pay for medical expenses incurred by Medicare beneficiaries. Under Section 1862 (b)(8) of the Social Security Act, there is a daily $1,000 penalty for failure to report. Section 4 of the legislation would allow penalties at the discretion of the Secretary of the Department of Health and Human Services and also require notice-and-comment rulemaking to establish the conditions under which penalties will be assessed. CBO expects that this provision could reduce the penalties levied on insurers, but estimates that the amount of the change in penalty collections would not be significant.

Section 5 would direct the Secretary to modify the reporting requirements under the Medicare Secondary Payer (MSP) statute to make optional the use of beneficiaries' Social Security Numbers or Health Insurance Claim Numbers. H.R. 1063 would require the Secretary to change reporting requirements within 18 months of the legislation's enactment, but allows multiple one-year extensions if the Secretary notifies the relevant Congressional committees that such an extension is necessary to ensure beneficiary privacy or the efficient operation of the MSP system. CBO expects that the Secretary would receive multiple extensions of the deadline for this new requirement. As a result, CBO estimates that provision would have no significant budgetary effect over the 2013–2022 period.

Section 6 would shorten the statute of limitations with respect to the federal government's ability to bring a complaint against an insurer or other third party for failure to comply with the MSP statute. CBO estimates that this provision would have no significant budgetary impact.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 1063, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON SEPTEMBER 20, 2012

	By fiscal year, in millions of dollars—											
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013–2017	2013–2022
NET INCREASE OR DECREASE (−) IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	−2	−4	−4	−4	−4	−5	−5	−5	−6	−6	−18	−45

Intergovernmental and private-sector impact: H.R. 1063 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal costs: Lara Robillard; Impact on state, local, and tribal governments: Lisa Ramirez-Branum; Impact on the private sector: Alexia Diorio.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 establishes the short title of the bill as the "Strengthening Medicare And Repaying Taxpayers Act of 2012".

Sec. 2. Determination of reimbursement amount through CMS website to improve program efficiency

Section 2 requires the Secretary to maintain and make available to individuals to whom items and services are furnished under this title (and representatives) access to information through a website for items and services (including payment amounts) for claims that are attributable to a specific injury or incident that forms the basis for a settlement, judgment, award, or other payment relating to an injury or incident to which this subsection applies. The Secretary shall update this website for any payment or claims information within 15 days of receipt of such claim or payment made, respectively. Upon notice of intent to settle, the Secretary has a protected period of no less than 65 days, but no more than 95 days (except for exceptional circumstances), in which to post claims received or payments made on the website. After conclusion of the protected period, but no more than 72 hours from the date of settlement, parties subject to repayment are required to draw down the final conditional payment amount from the website.

The bill requires the Secretary to respond promptly when notified of a discrepancy related to repayment amounts posted on the website and create a right of appeals, through regulation, for determinations made under this subsection.

Sec. 3. Fiscal efficiency and revenue neutrality

Section 3 requires the Secretary to calculate, on an annual basis, a single threshold amount under which the cost of seeking repayment of a claim costs the Medicare program more than it expects to receive in repayment. Such threshold shall be reviewed by the Comptroller General of the United States and submitted to Congress no later than November 15 of each year.

Sec. 4. Reporting requirement

Section 4 changes the current mandatory $1,000 per day per claimant penalty for reporting failures under the Medicare Secondary Payer statute to a requirement that parties "may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant" in order to allow the Secretary more discretion when assessing fines. Such a change reflects the committees desire to grant the Secretary more flexibility when dealing with good faith efforts.

Sec. 5. Use of social security numbers and other identifying information in reporting

Section 5 requires the Secretary to modify existing reporting requirements within 18 months of enactment so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers. This deadline may be extended annually if the Secretary certifies to the committees of jurisdiction in the House and Senate that such a system threatens patient privacy or the integrity of the Medicare Secondary Payer system.

Sec. 6. Statute of limitations

Section 6 creates a statute of limitations under the Medicare Secondary Payer statute so that the Medicare program may not seek repayment from beneficiaries or other related parties three years after the date the Secretary receives a notice of settlement.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART E—MISCELLANEOUS PROVISIONS

* * * * * * *

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) * * *
(b) MEDICARE AS SECONDARY PAYER.—
(1) * * *
(2) MEDICARE SECONDARY PAYER.—
(A) * * *
(B) CONDITIONAL PAYMENT.—

(i) * * *

(ii) REPAYMENT REQUIRED.—[A primary plan] *Subject to paragraph (9), a primary plan*, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) ACTION BY UNITED STATES.—In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan. *An action may not be brought by the United States under this clause with respect to payment owed unless the complaint is filed not later than 3 years after the date of the receipt of notice of a settlement, judgment,*

award, or other payment made pursuant to paragraph (8) relating to such payment owed.

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(vii) USE OF WEBSITE TO DETERMINE FINAL CONDITIONAL REIMBURSEMENT AMOUNT.—

(I) NOTICE TO SECRETARY OF EXPECTED DATE OF A SETTLEMENT, JUDGMENT, ETC.—In the case of a payment made by the Secretary pursuant to clause (i) for items and services provided to the claimant, the claimant or applicable plan (as defined in paragraph (8)(F)) may at any time beginning 120 days before the reasonably expected date of a settlement, judgment, award, or other payment, notify the Secretary that a payment is reasonably expected and the expected date of such payment.

(II) SECRETARY PROVIDING ACCESS TO CLAIMS INFORMATION THROUGH A WEBSITE.—The Secretary shall maintain and make available to individuals to whom items and services are furnished under this title (and to authorized family or other representatives recognized under regulations and to an applicable plan which has obtained the consent of the individual) access to information on the claims for such items and services (including payment amounts for such claims), including those claims that are attributable to a specific injury or incident that forms the basis for a settlement, judgment, award or other payment relating to an injury or incident to which this subsection applies. Such access shall be provided to an individual, representative, or plan through a website that requires a password to gain access to the information. The Secretary shall update the information on claims and payments on such website in as timely a manner as possible but not later than 15 days after the date of receipt of such claims or the making of such payments, respectively. Information related to claims and payments subject to the notice under subclause (I) shall be maintained and made available consistent with the following:

(aa) The information shall be as complete as possible and shall include provider or supplier name, diagnosis codes (if any), dates of service, and conditional payment amounts.

(bb) The information accurately identifies those claims and payments that are related to an injury or incident to which the provisions of this subsection apply.

(cc) The website provides a method for the receipt of secure electronic communications with the individual, representative, or plan involved.

(dd) The website provides that information is transmitted from the website in a form that

includes an official time and date that the information is transmitted.

(ee) The website shall permit the individual, representative, or plan to download a statement of reimbursement amounts (in this clause referred to as a "statement of reimbursement amount") on payments for claims under this title relating to a specific injury or incident of the individual.

(III) USE OF TIMELY WEB DOWNLOAD AS BASIS FOR FINAL CONDITIONAL AMOUNT.—If an individual (or other claimant or applicable plan with the consent of the individual) obtains a statement of reimbursement amount from the website during the protected period as defined in subclause (V) and the related settlement, judgment, award or other payment is made during such period, then the last statement of reimbursement amount that is downloaded during such period and within 3 business days before the date of the settlement, judgment, award, or other payment shall constitute the final conditional amount subject to recovery under clause (ii) related to such settlement, judgment, award, or other payment.

(IV) RESOLUTION OF DISCREPANCIES.—If the individual (or authorized representative) believes there is a discrepancy with the statement of reimbursement amount, the Secretary shall provide a timely process to resolve the discrepancy. Under such process the individual (or representative) must provide an alternate final conditional payment amount and documentation of the basis for such alternate amount. Within 15 days after the date of receipt of such documentation, the Secretary shall determine whether there is a reasonable basis for such alternate final conditional payment amount. If the Secretary does not make such determination within the 15-day period, then the alternate final conditional payment amount shall become the final conditional payment amount. If the Secretary determines within such period that there is not a reasonable basis for the alternate amount, the original final conditional payment amount is reconfirmed. If the Secretary determines within such period that there is a reasonable basis for an alternate final conditional payment amount, the Secretary must respond in a timely manner by agreeing to the alternative final conditional payment amount or by providing documentation showing with good cause why the Secretary is not agreeing to such amount and either reconfirming the original final conditional payment amount or establishing another alternative final conditional payment amount. In no case shall the process under this subclause be treated as an appeals proc-

ess or as establishing a right of appeal for a statement of reimbursement amount and there shall be no administrative or judicial review of the Secretary's determinations under this subclause.

(V) PROTECTED PERIOD.—In subclause (III), the term "protected period" means, with respect to a settlement, judgment, award or other payment relating to an injury or incident, the portion (if any) of the period beginning on the date of notice under subclause (I) with respect to such settlement, judgment, award, or other payment that is after the end of a Secretarial response period beginning on the date of such notice to the Secretary. Such Secretarial response period shall be a period of 65 days, except that such period may be extended by the Secretary for a period of an additional 30 days if the Secretary determines that additional time is required to address claims for which payment has been made. Such Secretarial response period shall be extended and shall not include any days for any part of which the Secretary determines (in accordance with regulations) that there was a failure in the claims and payment posting system and the failure was justified due to exceptional circumstances (as defined in such regulations). Such regulations shall define exceptional circumstances in a manner so that not more than 1 percent of the repayment obligations under this subclause would qualify as exceptional circumstances.

(VI) EFFECTIVE DATE.—The Secretary shall promulgate final regulations to carry out this clause not later than 9 months after the date of the enactment of this clause.

(VII) WEBSITE INCLUDING SUCCESSOR TECHNOLOGY.—In this clause, the term "website" includes any successor technology.

(viii) RIGHT OF APPEAL FOR SECONDARY PAYER DETERMINATIONS RELATING TO LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS.—The Secretary shall promulgate regulations establishing a right of appeal and appeals process, with respect to any determination under this subsection for a payment made under this title for an item or service for which the Secretary is seeking to recover funds from an applicable plan (as defined in paragraph (8)(F)) that is a primary plan under subsection (A)(ii), under which the applicable plan involved, or an attorney, agent, or third party administrator on behalf of such plan, may appeal such determination. The individual furnished such an item or service shall be notified of the plan's intent to appeal such determination.

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(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO

FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS.—

(A) * * *

(B) REQUIRED INFORMATION.—The information described in this subparagraph is—

(i) * * *

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Not later than 18 months after the date of enactment of this sentence, the Secretary shall modify the reporting requirements under this paragraph so that an applicable plan in complying with such requirements is permitted but not required to access or report to the Secretary beneficiary social security account numbers or health identification claim numbers, except that the deadline for such modification shall be extended by one or more periods (specified by the Secretary) of up to 1 year each if the Secretary notifies the committees of jurisdiction of the House of Representatives and of the Senate that the prior deadline for such modification, without such extension, threatens patient privacy or the integrity of the secondary payer program under this subsection. Any such deadline extension notice shall include information on the progress being made in implementing such modification and the anticipated implementation date for such modification.

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(E) ENFORCEMENT.—

(i) IN GENERAL.—An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant [shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant.] *may be subject to a civil money penalty of up to $1,000 for each day of noncompliance with respect to each claimant.* The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

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(I) REGULATIONS.—Not later than 60 days after the date of the enactment of this subparagraph, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for the specification of practices for which sanctions will and will not be imposed under subparagraph (E), including not imposing sanctions for good faith efforts to identify a beneficiary pursuant to this paragraph under an applicable entity responsible for reporting information. After considering the proposals so submitted, the Secretary, in consultation

with the Attorney General, shall publish in the Federal Register, including a 60-day period for comment, proposed specified practices for which such sanctions will and will not be imposed. After considering any public comments received during such period, the Secretary shall issue final rules specifying such practices.

(9) EXCEPTION.—

(A) IN GENERAL.—Clause (ii) of paragraph (2)(B) and any reporting required by paragraph (8) shall not apply with respect to any settlement, judgment, award, or other payment by an applicable plan constituting a total payment obligation to a claimant of not more than the single threshold amount calculated by the Secretary under subparagraph (B) for the year involved.

(B) ANNUAL COMPUTATION OF THRESHOLDS.—Not later than November 15 before each year, the Secretary shall calculate and publish a single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from liability insurance (including self-insurance) and for alleged physical trauma-based incidents (excluding alleged ingestion, implantation, or exposure cases) subject to this section for that year. Each such annual single threshold amount for a year shall be set such that the expected average amount to be credited to the Medicare trust funds of collections of conditional payments from such settlements, judgments, awards, or other payments for each of liability insurance (including self-insurance), workers' compensation laws or plans, and no fault insurance subject to this section shall equal the expected cost of collection incurred by the United States (including payments made to contractors) for a conditional payment from each of liability insurance (including self-insurance) and alleged physical trauma- based incidents (excluding alleged ingestion, implantation or exposure cases) subject to this section for the year. At the time of calculating, but before publishing, the single threshold amount for a year, the Secretary shall inform, and seek review of, the Comptroller General of the United States with regard to such amount. The Secretary shall include, as part of such publication for a year—

(i) the expected cost of collection incurred by the United States (including payments made to contractors) for a conditional payment arising from liability insurance (including self-insurance) and from alleged physical trauma-based incidents (excluding alleged ingestion, implantation or exposure cases; and

(ii) a summary of the methodology and data used by the Secretary in computing each such threshold amount and such cost of collection.

(C) TREATMENT OF ONGOING EXPENSES.—For purposes of this paragraph and with respect to a settlement, judgment, award, or other payment not otherwise addressed in clause (ii) of paragraph (2)(B) involving the ongoing responsibility for medical payments, such payment shall include only the cumulative value of the medical payments made.

(D) REPORT TO CONGRESS.—Not later than November 15 before each year, the Secretary shall submit to the Congress a report on a single threshold amount for settlements, judgments, awards, or other payments for conditional payment obligations arising from each of liability insurance (including self-insurance) claims for ingestion, implantation and exposure cases, workers compensation cases, and no fault insurance cases subject to this section for that year. For each such report, the Secretary shall—

(i) calculate each such threshold amount by using the methodology described in subparagraph (B); and

(ii) include a summary of the methodology and data used in calculating each such threshold amount and the amount of expected savings under this title achieved by the Secretary implementing such thresholds.

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